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A STUDY TO DETERMINE THE BEST WAY FOR LETTERMAN ARMY MEDICAL CENTER TO COMPLY WITH THE 1981 JCAH QUALITY ASSURANCE STANDARD

A Problem Solving Project

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This study compares the new 1981 JCAH quality assurance standards with Letterman Army Hospital's current quality assurance practices to determine what changes will be necessary to meet the new requirements.

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CHAPTER I

INTRODUCTION

First Endeavors to Attain Quality Assurance

Contrary to the impression which some noted authorities on the subject of medical care quality assurance (QA) might leave with their less well informed and mistaken readers, the concept of QA has been with us for many centuries. It would appear that some believe QA to be a very recent development because the form and intensity of such concerns have not remained consistent over all the thousands of years which have passed since their initiation.

Among the first of such efforts--if not actually the original--was the Code of Hammurabi, the king of Babylonia around the year 2000 B.C. Under this Code, payment for medical services was made to the practitioner only upon recovery of the patient. (This may also have been the first employment of the outcome measurement methodology.) The fee for services was determined by the Code and was based upon the patient's ability to pay as well as the seriousness of the condition treated. The following exerpts from the Code illustrate the QA aspects of it:

> If a man's child has died under the care of a nurse, and the nurse has substituted another (nurse) without consent of his father and the mother, the breasts of that nurse shall be cut off.[1]

> If a doctor operates on a wound with a copper lancet, and the patient dies, or on the eye of a gentleman who loses his eye in consequence, his hands shall be cut off.[2]

In another time and place--ancient China--subscribers to a kind of national health insurance paid the acupuncture doctor to keep them from getting sick. If the patient did become ill, in spite of the doctor's preventive medicine efforts, the doctor paid the patient.[3]

More Contemporary Quality Assurance Endeavors

Over the centuries which have passed since these early efforts at quality assurance, the severity and the forms of this kind of quality control have changed, but the need for them certainly has not. In our own contemporary society, there are several well recognized reasons for having an effective quality assurance system. Among these are the increased role and expectations of the society as a whole--and community members as individuals--in the determination of how, where, when, and what medical services should be provided; the legitimate interest of the third party payers; trends in malpractice litigation results; and the federal health legislation which has already been passed or is on the horizon. While each of these reasons, and others, can be discussed at length separately, they ultimately converge at one focal point of overriding importance--the judicially and legislatively established accountability of the hospital for the organization and delivery of medical care which meets acceptable standards.

Recognizing the increasing significance of the concept of an effective QA system in the delivery of health care, in 1972 the American Hospital Association (AHA) developed guidelines for the administration of a quality assurance program (QAP) for hospital medical services, with authority and accountability delegated to the medical staff.[4] The presence of such a program not only implied a commitment to measurement and evaluation of the quality of care--it also implied a commitment to take corrective action if care does not meet the criteria of quality.[5] This resulting system of quality <u>assurance</u> became known as <u>peer review</u>, and was based upon five fundamental elements or steps:

Step A - Criteria development.

Step B - Description of the actual practice.

Step C - Judgement or evaluation. (Does B = A?)

Step D - Corrective action. (If B $\neq$ A.)

Step E - Reassessment. (After D, does B = A?)[6]

Continuing from the AHA program guidance, the QAP for medical services was to be conducted by a hospital QAP committee, or committees, which usually developed two major subcommittees to carry out steps A, B, and C of the procedure described above. These subcommittees were described as follows:

1. Utilization review committee to carry out measurement of use of available facilities and services to insure that the patient receives the appropriate <u>amount</u> of care--neither <u>over</u>utilization nor <u>under</u>utilization; i.e., assurance

has not been the only one used in QA endeavors. The Quality Review Bulletin cites some ten other approaches to QA: tracers, health accounting, staging, the bi-cycle model, Quality Assurance Monitor, Comprehensive Quality Assurance System, California Medical Association/California Hospital Association Educational Patient Care Audit, Concurrent Quality Assurance, California Medical Insurance Feasibility Study, and criteria mapping.[8] The PEP methodology is emphasized in this discussion because it has been the most prevalently employed QA procedure.

A New Direction for Quality Assurance

In its May/June 1979 publication of Perspectives on Accreditation, the Joint Commission on Accreditation of Hospitals reported the approval of a new quality assurance standard for hospitals by the JCAH Board of Governors.[9]

The principle for the new JCAH QA standard is as follows:

> The hospital shall demonstrate a consistent endeavor to deliver patient care that is optimal within available resources and consistent with achievable goals. A major component in the application of this principle is the operation of a quality assurance program.[10]

The standard for determination of compliance is as follows:

> There shall be evidence of a well-defined, organized program designed to enhance patient care through the ongoing objective assessment of important aspects of patient care and the correction of identified problems.[11]

Significant requirements of the new standard are:

of the necessity of the care, economical employment of the facilities and services used, and conformity to predetermined criteria of optimal use.

2. Medical audit committee to measure the care received and compare it with a set of criteria for high-quality care--the system of peer review.[7]

To facilitate the provision and use of a simple and practical procedure for evaluating the quality of patient care in hospitals, the Joint Commission on Accreditation of Hsopitals (JCAH) published a Procedure for Retrospective Medical Care Audit in Hospitals in 1972, the Procedure for Retrospective Patient Care Audit in Hospitals in 1973, and the Performance Evaluation Procedure for Auditing and Improving Patient Care--also known as The PEP Primer--in 1974 (first edition) and 1975 (second edition).

The PEP Primer has recently served as the bible for the conduct of audit procedures, and prescribed the following sequence of activities in the performance of an audit:

Step 1: Specifying the topic and constructing measures of quality patient care.

Step 2: Measuring actual practice against criteria.

Step 3: Reviewing the data and analyzing variances.

Step 4: Analyzing deficiencies and planning corrective action.

Step 5: Planning follow-up.

Step 6: Communicating the audit summary.

The reader should be aware that the PEP methodology

- A comprehensive QA program.
- A written plan.
- An annual reassessment of the plan.
- A problem-focused approach to the review and evaluation of patient care and clinical performance.
- An improvement in patient care/clinical performance.[12]

Statement of the Problem

The problem was to determine the best way for Letterman Army Medical Center to comply with the new Joint Commission on Accreditation of Hospitals requirement for a written quality assurance plan, and to prepare a proposed concept of compliance and a written plan for submission to the Commander, Letterman Army Medical Center.

Limitations

The following limiting factors were present during the conduct of this project:

1. The study was conducted with only presently available administrative residency fiscal and personnel resources.

2. Instructional or advisory literature on compliance with the new JCAH QA standard was very limited because of the very recent development, approval, and publication of the new QA standard.

3. Experiential literature and other data on implementation of the new JCAH QA standard, and evaluation of the

implementation by the JCAH, will not be available until after January 1, 1981--the date when the new QA standard will become effective for accreditation purposes.

FOOTNOTES

[1]E. A. Wallis Budge, Babylonian Life and History, 2nd ed. (London: Religious Tract Society, 1925), p. 128, quoted in Claude S. George, Jr., The History of Management Thought, 2nd ed. (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1972), p. 10.

[2]Budge, p. 218, quoted in George, p. 10.

[3]Shiela Ostrander and Lynn Schroeder, Psychic Discoveries Behind the Iron Curtain (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1970), p. 224.

[4]American Hospital Association, Quality Assurance Program for Medical Care in the Hospital (Chicago: American Hospital Association, 1972), Section 1, p. 1.

[5]Ibid., Section 3, p. 1.

[6]Ibid.

[7]Ibid., Section 4, pp. 1-2.

[8]Audrone Vanagunas, "Quality Assessment: Alternative Approaches," Quality Review Bulletin (February 1979), pp. 7-10.

[9]Joint Commission on Accreditation of Hospitals (JCAH), "New QA Standard Approved," Perspectives on Accreditation (May/June 1979), p. 1.

[10]JCAH, Accreditation Manual for Hospitals (AMH) (Chicago: JCAH, 1980), p. 151.

[11]Ibid.

[12]JCAH, "An Explanation of the New Quality Assurance Standard," Perspectives on Accreditation (May/June 1979), p. 7.

CHAPTER II

THE 1981 JCAH STANDARD FOR QUALITY ASSURANCE

Historical Background

The Joint Commission on Accreditation of Hospitals (JCAH) traces its origins back to the Hospital Standardization Program established by the American College of Surgeons in 1918. With the years that followed, it became apparent to the Board of Commissioners that the nation's hospitals were eager to achieve more than a required minimum level of standardization, and the Board chose to pursue the following objectives in 1966:

1. Raise and strengthen the standards for hospital accreditation from a level of minimum essential to the level of optimum achievable.

2. Simplify and clarify the language of standards and interpretation.[1]

On April 7, 1979, the JCAH Board of Commissioners approved a revised quality assurance standard for hospitals.

> There shall be evidence of a well-defined, organized program designed to enhance patient care through the ongoing objective assessment of important aspects of patient care and the correction of identified problems.[2]

This new standard represents the first total revision of the JCAH QA standard for hospitals since 1970, and eliminated Standard I of the Quality of Professional Services (QPS)

section of the Accreditation Manual for Hospitals (AMH). More significantly, it eliminated the numerical requirements for audit specified in Appendix B of the 1979 edition of the AMH. These requirements specified the number of audit studies required at the time of the JCAH survey, as determined by the number of hospital admissions for the calendar year immediately preceeding the survey.[3]

The elimination of the numerical requirement for audit has been welcomed by many health care providers as a step toward ending mere paper compliance with the JCAH standards.[4] However, the problem for providers has not been eliminated--it has merely changed from a numerical requirement to one of determining how to best comply with the non-quantitative 1981 standard. The Board of Commissioners has allowed for this transition by making the new QA standard effective only for consultative purposes since its approval, and effective for accreditation decision purposes only after January 1, 1981.

Requirements for 1981

As a result of the new JCAH philosophical direction, the development and implementation of programs to comply with the 1981 QA standard should result in the delivery of patient care which is closer to optimal for each hospital than was the case with the requirement for a specified number of audit studies. The new QA standard is the result of a JCAH recognition of the many valid and useful methods of patient care review and evaluation which are being used and which are

readily pertinent and applicable to identified problems. It also seeks to have providers coordinate and integrate these other ongoing QA-related activities--other than audits--into a more comprehensive QA program. These other useful activities and methods of patient care review and evaluation include tissue review; blood utilization review; drug utilization review; medical record adequacy review; review of all deaths, unimproved cases, errors in diagnosis and treatment, and unresolved problem cases; etc. At the same time, the audit study technique remains as a potentially effective and appropriate instrument for clarifying and resolving problem areas--both clinical and administrative--which have been identified.

The JCAH interpretation of the 1981 QA standard points out that there are several components which are essential to a sound QA program:

- Identification of important or potential problems related to patient care.
- Assessment of the cause and scope of problems.
- Determination of priorities for investigating and resolving problems.
- Implementation of solutions for identified problems.
- Monitoring activities which assure the desired result.
- Documentation of the existence and effectiveness of the overall program.[5]

Other interpretation guidance from the 1980 edition of the AMH points out that the administration or coordination of the overall QA program may be performed by a committee, group, or individual. Annual reappraisal through a designated mechanism must be made to insure the program is ongoing, comprehensive, effective in the improvement of patient care, and cost effective.

As a closing comment, the interpretation of the standard notes that the effectiveness of a hospital's quality assurance program shall be emphasized in the determination of the hospital's accreditation status.

Further elaboration on the significant requirements of the QA program standard are presented in the following discussion.

Written Plan

A written plan must be prepared to fully and acurately document and describe the existence and implementation of the QA program. It also is intended to assist in insuring the comprehensiveness of the QA program, as well as serving as a procedural guide for the staff on such fundamental considerations as the following:

- Purpose(s) of the QA program.
- Scope of the program--outline of comprehensiveness.
- Description of how the program will be implemented.
- Roles of key groups and individuals.
- Committee/board memberships.
- Purpose and required activities of each committee/

board.

- Reporting and coordination responsibilities.
- Procedural instructions--how problems are to be identified, how priorities are to be established, how follow-up should be managed, etc.
- An organization chart depicting the lines of authority, accountability, coordination, etc.
- Provision for annual review of the program.

Comprehensiveness

All quality assurance monitoring activities are to be included as parts of a well-coordinated, fully integrated, amd representative hospital-wide program. A typical hospital might have the following monitoring activities:

- Credentialing.
- Tissue/Surgical case review.
- Morbidity/mortality review.
- Pharmacy and therapeutics review.
- Blood utilization review and evaluation.
- Antibiotic review and evaluation.
- Nursing care review and evaluation.
- Infection control.
- Safety.
- Utilization review.
- Risk management.
- Continuing education.
- Accreditation.
- Patient assistance.

- Etc.

Each clinical or patient care department or service must be represented within this monitoring mechanism. Communication and coordination among these monitoring activities is essential to a comprehensive QA plan, and there must be a profound recognition of the interdependence of the various clinical departments and services in the provision of quality patient care. This vital sharing of information among all clinical departments and services greatly improves the potential for the following benefits: identification and resolution of problems, elimination of unnecessary duplication of effort, promotion of increased awareness of the importance of a comprehensive and well coordinated effort, presence of an increased sense of teamwork and cohesiveness which sometimes becomes lost in large organizations, and--most importantly--enhancing the potential for improving patient care.

If it is found that one or some existing monitoring activities are not included in this vital communications network, these omissions must be corrected. Further, if some departments or services are not conducting monitoring activities, these efforts must be initiated and documented properly. Also, the results of these comprehensiveness endeavors must be fully reported to the chief executive officer, the chief of the medical staff, and the governing body.

Problem-focused Approach

The problem-focused approach--in this writer's opinion--is the keystone to the new QA program philosophy.

The JCAH standard specifically addresses the goal of improved patient care through an ongoing assessment of clinical and related activities, and the correction of identified problems. The focus on the resolution of known, suspected, or potential problems is vital to an effective QA program, and cannot be understated in its importance.

This emphasis on a problem-focused approach is a natural outcome of the experience with the audit methodologies which were used through the 1970's. While these audits of the most commonly found diagnoses and procedures frequently resulted in the identification of problems related to patient care, just as often or more frequently what was documented was merely the delivery of reasonable care--which had little relationship to patient outcomes.[6] In other words, while high quality care was being documented, and the requirement for a specified number of audits was being satisfied, problems which were resolvable within the hospital's existing resources were not always found or solved. This experience eventually lead to the conclusion that the audit process, although sometimes capable of identifying problems, was too formal, expensive, time consuming, and cumbersome for revealing the few problems which were discovered and was not worth the resources invested for the information gained. A more economical model for identifying and addressing problems was required, and the JCAH problem-focused approach should more directly, economically, and efficiently confront actual, suspected, or potential difficulties in the delivery of quality

patient care.

The JCAH suggests the use of five basic procedures in the employment of an effective problem-focused approach:

1. Identify problems and determine priorities for resolution.

2. Set standards and criteria.

3. Select and implement appropriate assessment methods.

4. Implement corrective action.

5. Evaluate and monitor problem resolutions.[7]

Problems and Priorities

The meaning of identification of problems is fairly straightforward. This is the first step in the classical theory of problem solving, although it is frequently easy-to-say and hard-to-do. As far as the JCAH will be concerned in 1981, a finding of "no problems" will be unacceptable.

Data Sources for problem identification include:

- Medical records.
- Concurrent patient care monitoring.
- Utilization review studies and data.
- Professional Standards Review Organization (PSRO) information.
- Health Services Command (HSC) Command Performance information.
- Financial management studies.
- Risk management information.
- Review of prescriptions.

- Audit conclusions.
- Patient surveys.
- Staff surveys.
- Third party payer/fiscal intermediary information.
- Professional Activities Study (PAS) information.
- Monitoring activity (committees, boards, etc.) proceedings.
- Incident reports.
- Literature reviews.
- Etc.

Problem categories such as the following might also be used to suggest the presence and nature of potential problem areas:

- Deviation from expected outcomes.
- Disagreement about expected outcomes.
- Expected variation from 0% or 100% standard.
- Degree of compliance.[8]

Following problem identification, there must be a documentation of the selected solution(s), and the method which will be used to monitor the progress of the solution--i.e., the follow-up.

Once the problem/solution/follow-up requirements and resources have been determined, priorities for the resolution of problem areas must be established. This will require a very careful study of the resources required for the problem resolution, the total resources available, other priorities, determination of which problem resolutions will have direct

and indirect impact on patient care, the alternative courses of action which are available, and the optimal feasible selection of the available solutions.

In the final analysis, first priority must be given to the following problems:

- Problems having the most immediate impact on patient care.

- Problems having the most adverse impact on patient care.[9]

Standards and Criteria

Standards can be from internal or external sources. For example, a PSRO standard length of stay for a specific category of patient, a committee's standard for a specified rate of normal pathology reports about removed tissue for inquiry into apparently unnecessary surgical procedures, a nursing department's standard for an acceptable number of medication errors, etc. Standards can be explicit--i.e., based upon expert judgement, regional norms, or group consensus--or standards can be implicit--i.e., individual perceptions of what is acceptable.

Clinically valid criteria are necessary to insure that objectivity is evident in the review of problems which have been identified. These criteria must be written, and must reflect currently accepted practice as may be found in the clinical literature, local or regional norms, experience, consescus of the clinical staff, etc. Criteria employed may structure, process, or outcome criteria, as appropriate.

Assessment Methods

Assessment of an identified problem may be done prospectively, concurrently, or retrospectively. Regardless of which orientation or combination of orientations is employed, representative and adequate sampling of all clinical endeavors--all departments, services, disciplines, and practitioners--must be accomplished and evaluated.

Physician care must be evaluated by physician members of the medical staff. Other clinical care providers should assess the care which they provide. When appropriate, however, both physicians and non-physicians should be employed in the evaluation of patient care. Innovation and variation in assessment approaches should be encouraged and allowed whenever indicated.[10]

Corrective Action

Actions designed to solve problems can take any appropriate form--education or training programs, initiation of new or altered procedures, changes in staffing, equipment modification or changes, facility reconfigurations or additions, adjustments to clinical privileges, etc. The most important consideration is the sustained resolution of the problem. Results will count most in the eyes of the JCAH survey team members.

Regina Walczyk, JCAH staff member, has made the above noted point with the following remarks:

> If you're cited for anything, it will be for not solving a problem, not for how you examined it. Now, and in the future, we will not

> care how you resolved the problem, as long as you can demonstrate that it has been corrected. It's not what you did, but what resulted from what you did that will be looked at. That is where it's at. ...the bottom line will be, 'Did you or did you not solve the problems that you found?'[11]

After the problem sources and characteristics have been identified, solutions developed, and priorities established, a clear and precise documentation of the nature of and responsibilities for the corrective action(s) or intervention(s) must be made. In addition, a timetable of anticipated results should be established to facilitate the evaluation of progress during the reassessment process.

Evaluating and Monitoring Problem Resolution

The importance of the monitoring--or reassessment--function should not be overlooked because the objective of the entire QA exercise is not merely the solving of identified problems, but the sustained elimination or reduction of the problems. Once again, documentation will play an important role in the overall process. This documentation should include the following:

- How the evaluation and monitoring activities were originally intended to be accomplished and by whom.
- How the actual evaluation and monitoring activities really took place.
- The anticipated cost of the activities.
- The actual cost of the activities.
- Source(s) of standards for evaluation.
- How satisfactorily the problem resolution met the

appropriate standard at the time of the evaluation.

- Any indicated adjustments for either the resolution process or system itself.
- Any indicated adjustments for the standards used.
- Further recommendations, as appropriate.

Annual Review

The purpose of the annual review is to insure that the QA program continues to close gaps between the quality of care actually provided and the optimal level achievable at that institution. The annual review should focus upon the characteristics of the plan which are most likely to become overtaken by time and events--changes in the current clinical or administrative state of the art; available financial, personnel, and facility resources; changes in the patient population; progress in the sustained resolution of problems on the priority list; vigorous search for and identification of new problems; comprehensiveness; flexibility; cost effectiveness; documentation; and--again most importantly--improvement in the quality of patient care/clinical performance. The key question which must be honestly answered is this: Within the framework of a constantly changing mix of problems and resources, is the QA program having the desired impact on patient care which it was intended to have? Naturally, any gaps or inconsistencies must be corrected. Providers will have to insure that this annual review does not become a mere paper compliance. It must be a conscientious, objective evaluation of the progress which has <u>really</u> been made--if any

--in bringing the level of patient care/clinical performance closer to the optimum for the institution, and must address program adjustments which are indicated.

Improved Patient Care/Clinical Performance

The degree to which patient care/clinical performance has been improved must be demonstrated and documented. In the absence of any other type of such a demonstration, it seems that a summary of problems identified, solutions/interventions completed, and follow-up action taken would be prima facie evidence of the program's positive impact on patient care/clinical performance. Direct and indirect effects on patient care should be noted for this purpose. Quantitative improvements such as favorable changes in length of stay, nosocomial infection rates, mortality rates, medication errors, claims and/or legal initiatives, etc. would be superlative indicators of improved patient care/clinical performance.

FOOTNOTES

[1]Joint Commission on Accreditation of Hospitals (JCAH), Accreditation Manual for Hospitals (AMH) (Chicago: JCAH, 1980), pp. x-xi.

[2]Ibid., p. 151.

[3]JCAH, AMH (Chicago: 1979), p. 196.

[4]"New JCAH Quality Assurance Standard: Preliminary Requirements Emerge," Hospital Peer Review 4 (May 1979), p. 67.

[5]JCAH, AMH (1980), p. 152.

[6]JCAH, Seminar On Quality Assurance Workbook (Chicago: JCAH, 1979), p. 137.

[7]Ibid., p. 136.

[8]Ibid., pp. 163-164.

[9]JCAH, "An Explanation of the New Quality Assurance Standard," Perspectives on Accreditation (May/June 1979), p. 8.

[10]JCAH, AMH (1980), p. 152.

[11]"JCAH's New Quality Assurance Standard: Requirements Aired," Hospital Peer Review 4 (September 1979), pp. 114-116.

CHAPTER III

THE EXISTING LAMC QUALITY ASSURANCE PROGRAM: A SYSTEMS ANALYSIS DESCRIPTION

The following discussion will portray the present Letterman Army Medical Center quality assurance program from the standpoint of a systems analysis description--i.e., this discussion will describe the existing system and the way it functions. The LAMC QA program is depicted as a system in Figure 1, page 40.

Inputs

There are four major input sources in the Letterman quality assurance program, and a host of several lesser input sources. All of these are shown in Figure 1. The major input sources are:

- Audits.
- The Medical Care Evaluation/Utilization Review Committee.
- The Executive Committee.
- Incident reports (Reports of Unusual Occurrence, DA Form 4106)

Audits

Letterman Army Medical Center was required to conduct eight audits of medical care quality in 1979, based upon the

number of hospital admissions for calendar year 1978. To meet this audit requirement, the Departments of Surgery, Obstetrics/Gynecology, Medicine, Pediatrics, and Psychiatry were required to perform at least one audit during 1979, in accordance with applicable LAMC Regulations. In addition, the Dental Activity, the Department of Ambulatory Care, the Physical Medicine and Rehabilitation Service, and the Pharmacy Service were called upon to conduct audits. A total of twelve audits were conducted during 1979.

Following the elimination of the JCAH requirement to conduct a specified number of audits during the year preceeding a survey, the Letterman Army Medical Center Commander elected to voluntarily continue employment of the multidisciplinary patient care audit as a source of information regarding the quality of patient care/clinical performance.

For calendar year 1980, seven clinical departments or services will conduct eleven multidisciplinary patient care audits--one each by the Departments of Psychiatry, Pediatrics, Obstetrics/Gynecology, Surgery, and Medicine, quarterly audits by the Respiratory Care Service, and semi-annual audits by the Social Work Service.

In addition, during 1980, six re-audits of 1979 topics will be conducted to ascertain the degree of compliance which has been gained since the studies were completed last year.

The Medical Care Evaluation/ Utilization Review Committee

The heart of the existing LAMC QA system is the Medical Care Evaluation/Utilization Review (MCE/UR) Committee. According to LAMC Regulation 15-1, Hospital Boards, Committees, Conferences and Councils, the stated purpose of the MCE/UR Committee is as follows:

> To review and evaluate activities and recommendations of subordinate committees and hospital organizations engaged in quality assurance and utilization review.[1]

The Chairperson of the MCE/UR Committee is the Chief, Professional Services (CPS) and the members are:

- Executive Officer.
- Commander, Dental Activity.
- Chief, Department of Surgery.
- Chief, Department of Medicine.
- Chief, Department of Obstetrics/Gynecology.
- Chief, Department of Nursing.
- Chief, Department of Pediatrics.
- Chief, Department of Psychiatry.
- Chief, Department of Ambulatory Care.
- Chief, Department of Pathology.
- Chief, Department of Radiology.
- Chief, Physical Medicine and Rehabilitation Service.
- Chief, Pharmacy Service.
- Chief, Patient Administration Division.
- Medical Records Librarian.
- Chief, Comptroller Division.

- Chief, Social Work Service.
- Chief, Preventive Medicine Activity.
- Chief, Intensive Care Unit.
- Chief, Logistics Division.
- Chief, Food Service Division.
- Representatives of the following committees:

  Ambulatory Patient Care Committee.

  Blood Utilization Committee.

  Cardiopulmonary Arrest and Resuscitation Procedures Committee.

  Infection Control Committee.

  Tumor Board.[2]

Reports are submitted each month to the MCE/UR Committee by Departmental MCE/UR Subcommittees, which have the following common purpose:

> To document and evaluate the quality of care provided and recommend corrective action where appropriate; to document and evaluate the proper utilization of resources and their effective contribution to quality care and recommend corrective action where appropriate.[3]

Departmental MCE/UR Subcommittees are established by the following Departments and Services:

- Department of Surgery.
- Department of Obstetrics/Gynecology.
- Department of Medicine.
- Department of Pediatrics.
- Department of Psychiatry.
- Department of Ambulatory Care.
- Department of Nursing.

- Department of Radiology.
- Department of Pathology.
- Physical Medicine and Rehabilitation Service.
- Dental Activity.

Thus, the MCE/UR Committee is made up of a Chairperson, twenty-one members, and as many as five additional representatives--twenty-seven individuals charged with the review and evaluation of the activities and recommendations of subcommittees from nine clinical departments, one service, one activity, and also the review and evaluation of the activities and recommendations of five other subordinate committees represented within the MCE/UR Committee membership:

- Ambulatory Patient Care Committee.
- Blood Utilization Committee.
- Cardiopulmonary Arrest and Resuscitation Procedures Committee.
- Infection Control Committee.
- Tumor Board.

In reality, the Chairperson is the only MCE/UR Committee individual who routinely reviews the proceedings, recommendations, etc. of each of the subordinate committees and departmental MCE/UR subcommittees. This is the case in spite of the fact that all such records are available for the perusal of all MCE/UR Committee members.

The Executive Committee

The purpose of the Executive Committee is:

To receive, act upon and coordinate the

> recommendations of the medical staff and administrative committees concerned with patient care and monitor the implementation of the commander's decisions.[4]

The Chairperson of the Executive Committee is the LAMC Commander, and the members of the Executive Committee are:

- Chief, Professional Services.
- Executive Officer.
- Chief, Department of Nursing.
- Command Sergeant Major.

To accomplish its purpose, the Executive Committee reviews the minutes of the following committees:

- Accreditation/Disaster Planning Committee.
- Cancer Committee.
- Clinical Investigation/Human Use Committee.
- Health Consumer Advisory Committee.
- Medical Care Evaluation/Utilization Review Committee.*
- Program Budget Advisory Committee.
- Radioactive Drug Research Committee.
- Radioisotope/Radiation Control Committee.
- Safety Council.

*The minutes of the subordinate committees and departmental MCE/UR subcommittees are not reviewed by the Executive committee; only the parent MCE/UR Committee minutes are reviewed by the Executive Committee.

Incident Reports

Incident reports--DA Form 4106, Report of Unusual Occurrence--are initated primarily by the Department of Nursing personnel at Letterman Army Medical Center. They are used to report unusual occurrences or accidents involving patients. The most frequently reported occurrences are patient falls or other similar accidents (55%), medication administration errors by the nursing staff (16%), and lost needles in the operating rooms (6%).[5]

These reports are prepared in four copies, describing the incident, the recommended action to be taken, and the action taken or directed by higher authority such as the department or service chief. One copy is retained in the office of origin, one copy is sent to the Chief, Professional Services, one copy is sent to the LAMC Safety Manager, and the last copy is sent to the LAMC Staff Judge Advocate.

Other Input Sources

The remaining QA system input sources include the following.

Utilization Review Activities

Utilization review activities usually consist of studies concerned with patient length of stay, and other topics of interest such as the most economical utilization of the LAMC Medical Hold Company, the efficiency of the medical board process, and the cost of open heart surgery procedures for cardiac artery bypass graft patients.

Health Services Command Command Performance Summary information

HSC provides such information as the medical care cost per Medical Care Composite Unit (MCCU)[6], medical care supply cost per MCCU, hsopitalization cost per occupied bed day, clinic cost per clinic visit, pathology cost per weighted laboratory procedure, food service cost per ration served, length of patient stay, medical care personnel staffing ratio, etc.

Risk Management Endeavors

From all indications--i.e., few claims or lawsuits--the risk management program is quite prevention-oriented and very effective. There are several facets to the LAMC risk management program as a whole, although it does not appear to be a consciously coordinated effort, in spite of its effectiveness.

All new LAMC personnel attend an "Introduction to LAMC" orientation presented by the LAMC Commander, LAMC CPS, Chief Nurse, Executive Officer, etc. At that orientation, given each month, the importance of patient satisfaction is stressed--not because of the possibility of claims or lawsuits against LAMC and the federal government, but because good patient care and patient satisfaction should be the objectives of all efforts as worthwhile ends in themselves. What is unsaid is that the very small number of claims or lawsuits filed against the federal government is a beneficial by-product of concerned and quality patient care--not the objective of it.

The Department of Nursing recently initiated the use of patient questionnaires which ask for information on the degree of satisfaction with nursing care. These questionnaires are given to the patients at the time of their discharge.

Prior to any specific liability claim or lawsuit action, the LAMC Staff Judge Advocate is actively involved in a preventive liability effort which consists of the following prevention-oriented risk management actions:

- Coordination of an annual legal medical symposium.
- Conduct of three hours of instruction in the medical officer basic orientation program.
- In-service training throughout the medical center on the nature and hazards of hospital liability.

In general, medical providers--particularly physicians --are counselled by the SJA to take the following actions in any potential liability patient care case:

- Contact the LAMC SJA.
- Do not attempt to conceal any facts regarding the care provided.
- Document what took place and exactly how it happened.
- Counsel the patient and/or family about any clinical misgivings regarding the care provided, and document when, how, and where this was done.

Another aspect of the risk management endeavors is the review of incident reports.

The usual initial signal of a genuine potential

hospital liability case is the receipt of a request for copies of a patient's medical record from an attorney. If there is a potential liability case, the Patient Administration Division (medical records office) will contact the LAMC SJA for a legal review of the medical record. In the case of an apparent potential liability judgement, either the LAMC SJA or the U.S. Army Judge Advocate General Claims Service will initiate an investigation of the circumstances surrounding the case. In cases involving very large dollar amounts, the Armed Forces Institute of Pathology Department of Legal Medicine will conduct a review of the case to determine the apparent extent of the federal government's liability, if any.

According to the LAMC SJA records, the following claim and lawsuit actions were initiated and/or completed during 1979: eleven claims filed, four claims denied, no claims settled, four suits filed, and no suits settled. During the first four months of 1980 there have been four claims filed, three claims denied, two claims settled (one for $550,000 and one for $50), three suits filed, and one suit dismissed. (It should be noted that the first such action which may be taken against the federal government is the initiation of a claim, i.e., an administrative, nonjudicial procedure. If the claim is settled for a specific amount of damages, that is the end of that action. If the claim is denied, the claimant has a two year period during which a lawsuit may then be initiated, which may result in a cash settlement or dismissal.)

The LAMC SJA reports that the number of claims and/or lawsuits filed as a result of medical attention at LAMC is small, even in relation to the seven other HSC medical centers, because of the following reasons:

- Active duty patients cannot claim or file a lawsuit for damages under the provisions of the Federal Tort Claims Act. (However, military personnel injured while on authorized absence, veterans not injured on active duty, and dependents of military sponsors on active duty may file claims or lawsuits.)

- Having been a part of, and a beneficiary of, the federal system for many years, those eligible to file claims and/or lawsuits are reluctant to sue their benefactor.

- Many retired beneficiaries in the San Francisco Bay Area have been coming to LAMC with their medical care needs for many years. As a result of this long-term association with the institution and members of its staff, these patients do not seriously consider initiating a claim against the government in a case of potential liability. The key in this instance is their long-term satisfaction with the care given.[7]

Another facet of the LAMC risk management effort is the coordination between the LAMC Safety Council and the MCE/UR Committee by the LAMC Executive Officer, who is the Chairperson of the former council and a member of the latter committee. This interface insures integration and coordination of these two vital functions, and provides the authority to

resolve problems which are identified.

Inspector General Activities

The LAMC Inspector General is an occasional source of information through his role as a representative of the LAMC Commander in receiving patient complaints and inquiries, although relatively few of the comments and inquiries are related to the quality of patient care.

Patient Assistance Program

The Patient Assiatance office is located in the outpatient clinics area of LAMC so that patients requiring assistance can easily find a hospital point-of-contact specifically charged with receiving patient comments on the quality of care and other attention, and responding with appropriate information and assistance.

Other Quality Assurance-Related Committees

While not as directly or frequently involved in the patient care quality assurance process as the MCE/UR Committee, with its many subrdinate committees and departmental subcommittees, the following committees are regularly involved in the review of activities which are related to the quality of patient care in some way(s):

- Health Consumer Advisory Committee.
- Safety Council.
- Therapeutic Agents Board.
- Hospital Education Committee.
- Credentials Committee.

Miscellaneous Sources

Occasionally the following individuals at LAMC are the recipients of either formal or informal comments regarding the quality of care which come from any number of different sources: the LAMC Commander, the CPS, the Executive Officer, the Adjutant, the Chief Nurse, the Command Sergeant Major, the staff nurses, the receptionists, the secretaries, etc.

Transform

The transform--i.e., the structures and processes which convert the above noted inputs to outputs--is the analysis or decision making process of the LAMC Commander.

This cognitive process is best known only to the Commander, but it typically appears to follow the basic theme of the classical decision making process--identification of the problem, determination of alternative solutions, testing of the alternatives in some way, evaluation of the test results, and selection of the optimal feasible solution. As part of this process, there is an active and open consultation with appropriate members of the staff for suggestions on the formulation of a good problem definition, alternative solution possibilities, and recommended courses of action. Following that usual process, the Commander will provide the output of the system--his decision.

Outputs

The outputs--those things delivered or produced by the system--are the decisions of the Commander.

Feedback

The decisions of the Commander are next translated into some form of feedback--the return of output signals into the system. These signals usually take the form of LAMC policies, programs, or priorities, which are intended to result in or produce desired changes in the patient care/clinical performance of the LAMC health care delivery system.

Detector

The cybernetic system detector--the sensor for monitoring the presence of system performance deviation from the standard--usually takes the form of internal or external monitors or inspectors. These monitoring or inspection devices may be patient comments, JCAH survey results, LAMC Inspector General findings, HSC Inspector General visit reports, etc.

Feedforward

The typical situation in a bureaucracy such as Health Services Command includes the presence of prior information--or feedforward. Feedforward in an Army medical center includes directives, requirements, advice, etc. from the Office of the Surgeon General, HSC headquarters, JCAH, etc. Any before-the-fact information is feedforward.

Selector

The selector is the device which chooses the appropriate control option after the detector has signaled a deviation from the standard. In the case of a medical center, the selectors may include the Commander himself, or the appropriate subordinate specialists--the Chief, Professional Services; the Executive Officer; department chiefs; etc.

Effector

The effector is the Commander, who makes the decision to alter the system performance to reduce or eliminate the deviation of the patient care/clinical performance system from the standard.

* * * * *

For those readers less likely to experience some sort of euphoria, intoxication, or enchantment upon exposure to a systems analysis description and diagram of the present LAMC quality assurance system, a more conventional organization chart depicting the same system is provided at Figure 2.

FOOTNOTES

[1]Letterman Army Medical Center (LAMC), LAMC Regulation 15-1, Hospital Boards, Committees, Conferences and Councils (Presidio of San Francisco, California: LAMC, 1979), p. CC-1.

[2]Ibid., pp. CC-1 - CC-2. Unless otherwise indicated, all LAMC committee, and committee-type references and information are taken from LAMC Regulation 15-1.

[3]Ibid., p. P-1.

[4]Ibid., p. T-1.

[5]Percentages are based upon the relative frequency of these incidents as reported during calendar year 1979.

[6]The Medical Care Composite Unit (MCCU) is calculated as follows:

$$\text{MCCU's} = \frac{\text{Number of beds occupied} + (10 \times \text{number of admissions}) + (10 \times \text{number of live births}) + (.3 \times \text{number of clinic visits})}{\text{Number of days}}$$

[7]F. Ross Wooley at al, "The Effects of Doctor-Patient Communications on Satisfaction and Outcome of Care," Social Science and Medicine (December 1978), pp. 123-128, and Arline B. Sax, "Patient Relations in Risk Management," Quality Review Bulletin (April 1979), p. 14.

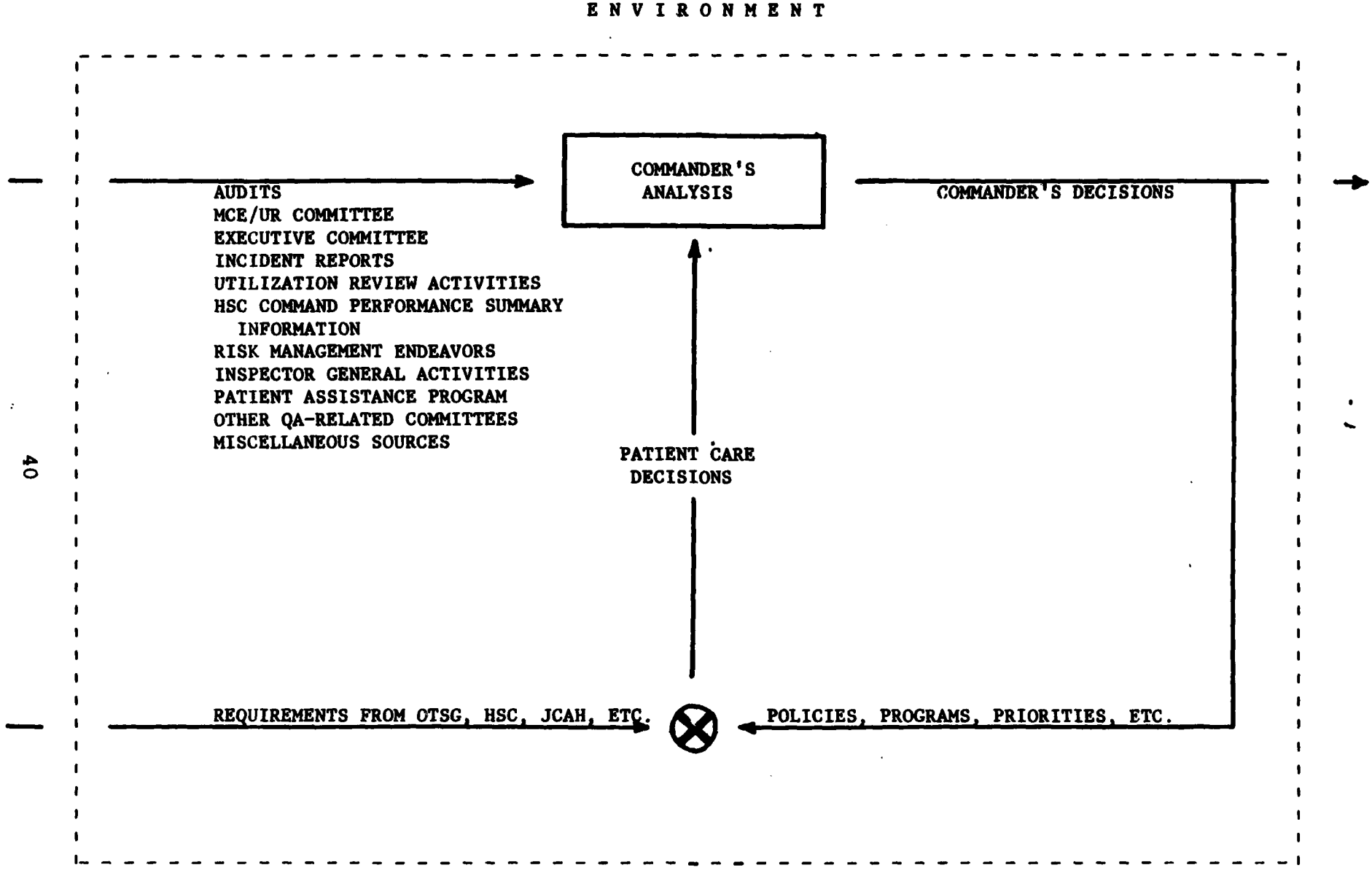
ENVIRONMENT
COMMANDER'S ANALYSIS
AUDITS
MCE/UR COMMITTEE
EXECUTIVE COMMITTEE
INCIDENT REPORTS
UTILIZATION REVIEW ACTIVITIES
HSC COMMAND PERFORMANCE SUMMARY INFORMATION
RISK MANAGEMENT ENDEAVORS
INSPECTOR GENERAL ACTIVITIES
PATIENT ASSISTANCE PROGRAM
OTHER QA-RELATED COMMITTEES
MISCELLANEOUS SOURCES
COMMANDER'S DECISIONS
PATIENT CARE DECISIONS
REQUIREMENTS FROM OTSG, HSC, JCAH, ETC.
POLICIES, PROGRAMS, PRIORITIES, ETC.

Figure 1

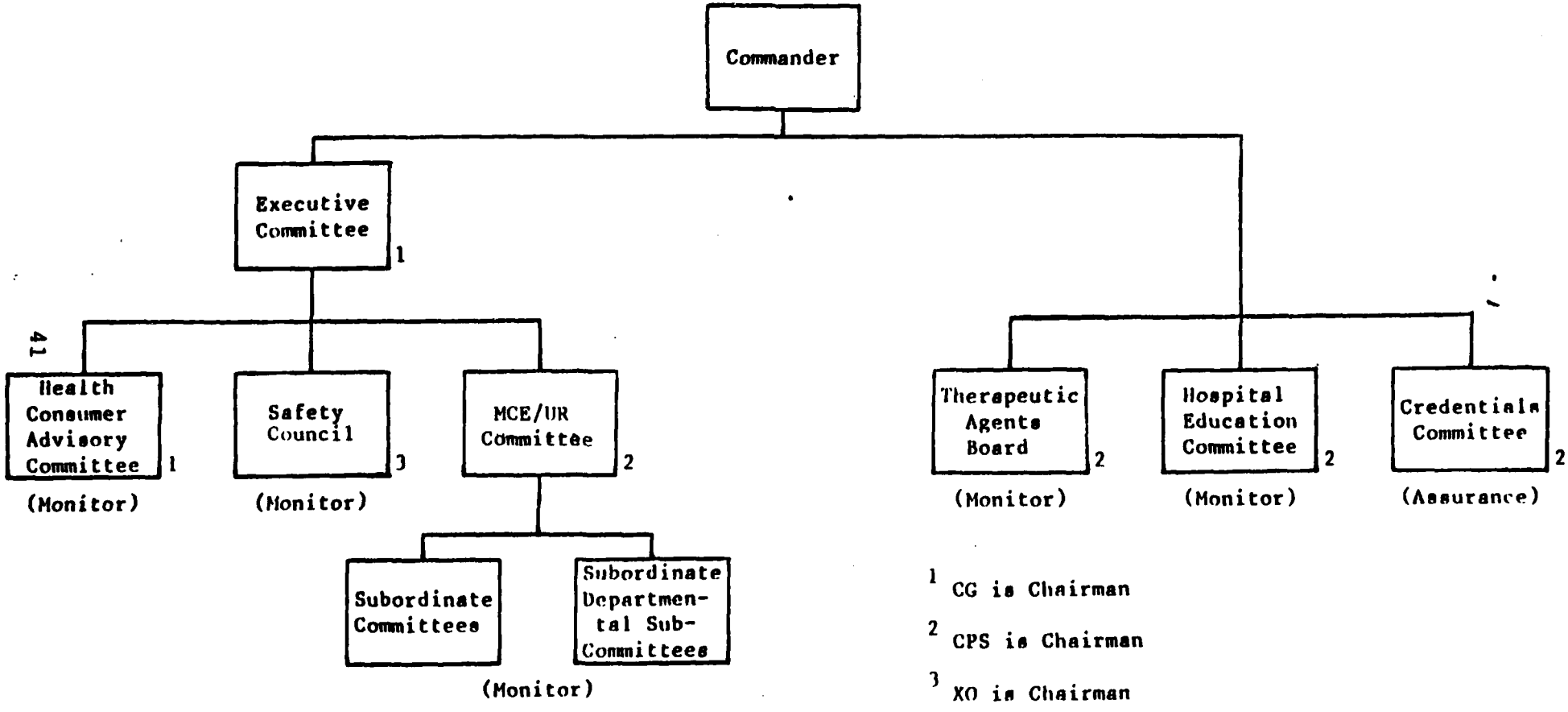
Commander
Executive Committee
1
41
Health Consumer Advisory Committee
1
(Monitor)
Safety Council
3
(Monitor)
MCE/UR Committee
2
Subordinate Committees
Subordinate Departmental Sub-Committees
(Monitor)
Therapeutic Agents Board
2
(Monitor)
Hospital Education Committee
2
(Monitor)
Credentials Committee
2
(Assurance)
1 CG is Chairman
2 CPS is Chairman
3 XO is Chairman
: Authority
: Coordination (Responsible Indiv.)

Figure 2

CHAPTER IV

DIFFERENCES BETWEEN THE LAMC QA PROCESS AND THE 1981 JCAH QA STANDARD

Conclusions from a comparative study of the 1981 JCAH QA standard and the QA process at Letterman Army Medical Center are presented below, using the JCAH's significant requirements for a QA program as a framework for discussion.

Copies of all QA-related committee and subcommittee minutes for 1979 were reviewed to establish the conclusions presented. These findings and conclusions were augmented by interviews with the LAMC Chief, Professional Services, and the LAMC Associate Administrator.

General Conclusion

Letterman Army Medical Center does indeed have a functioning quality assurance system. There is a very high level of commitment to quality patient care from the highest echelons of the medical center.

Although the committees and subcommittees involved are functioning in accordance with the LAMC regulation on boards and committees, the entire LAMC QA system is not documented in writing. There are some parts of the process which are functioning in accordance with local directives, there are some parts of the process which are not functioning in spite of the presence of very specific directives, and there are

some parts of the process which are indeed functioning in spite of the lack of written documentation or directives.

Review of the committee proceedings is done essentially by one individual, the Chief, Professional Services, who is the Chairperson of the MCE/UR Committee.

The LAMC QA process is quite comprehensive. The most conspicuous shortcoming within the system is the lack of a problem-focused approach. There are no provisions for an annual review, nor for the assessment of improved patient care or clinical performance.

Written Plan

Letterman Army Medical Center does have a plan for the committee structure which is the heart of the QA process. This plan is LAMC Regulation 15-1, Hospital Boards, Committees, Conferences and Councils. Specifically, LAMC Regulation 15-1 addresses the previously discussed Executive Committee, Medical Care Evaluation/Utilization Review Committee, and the Departmental MCE/UR Subcommittees. Also covered are the Ambulatory Patient Care Committee, Blood Utilization Committee, Cardiopulmonary Arrest and Resuscitation Procedures Committee, Infection Control Committee, and the Tumor Board.

Unfortunately, LAMC Regulation 15-1 does not provide any more than a brief purpose statement for these committees, making it very difficult to determine if they are really accomplishing all of the tasks that they are supposed to be doing. There is adequate information for most of the membership listings, meeting frequencies, etc.

The Departmental MCE/UR Subcommittees are not specifically nor respectively tasked with a purpose for each subcommittee, nor are the respective and separate memberships listed for each subcommittee. There is only a single reference to these subcommittees, simply tasking each listed clinical department to form one.

There is no comprehensive written plan which fully describes the complete QA process or system at LAMC. Such a plan must be prepared, staffed, and approved by the LAMC Commander. It must incorporate all of the descriptive information detailed in Chapter II of this paper--purpose and scope of the QA program, roles of key individuals and groups, committee memberships or appropriate references to LAMC Regulation 15-1, committee purposes, reporting and coordinating responsibilities, other required procedural information, an organization chart, provisions for annual review, etc.

Comprehensiveness

In order to be comprehensive, the QA system must insure that all available, pertinent clinical information is shared throughout the QA information network.

All clinical departments and services at LAMC do have monitoring committees which meet, even if not as regularly as prescribed in LAMC Regulation 15-1. However, the mechanism/individual for the essential synthesis and coordination of all of the information from the various minutes of these committees is grossly overloaded. The minutes of all of the sixteen separate monitoring committees and subcommittees

subordinate to the MCE/UR Committee are normally reviewed only by the Chairman of the MCE/UR Committee. While the JCAH states that QA program coordination may be performed by a committee, group, or individual, it certainly seems that a multi-disciplinary group would provide a much more comprehensive and easily managed monitoring of the overall QA program than is the case with only one individual carrying that workload alone.

Some committees do not meet regularly, as prescribed in LAMC Regulation 15-1. One committee--the Cardiopulmonary Arrest and Resuscitation Procedures Committee--has discontinued meeting without proper authority. Another committee--the Critical Care Committee--is meeting regularly, but is not included in the current changes to LAMC Regulation 15-1. These administrative details must be taken care of to preclude any more confusion on these committees.

There is one area of quality assurance which is not specifically addressed by a committee or subcommittee--antibiotic usage review and evaluation. This problem has been acknowledged by the LAMC CPS, and plans are being made to provide for such a review on a regular basis.

Problem-focused Approach

This all-important requirement of the 1981 standard is generally quite conspicuous by its absence. Problems have been identified at one time or another in almost all of the committee proceedings, but only one or two identify problems with any consistency, and none focus on a complete problem/

solution/follow-up format or approach. Solutions are seldom noted, and follow-up is an unknown concept.

This lack of a problem-seeking orientation appears to be the case because there has not been any specific guidance or requirement to adopt a problem-focused approach prior to the announcement of the 1981 JCAH QA standard. As a result, none of the committee/subcommittee purpose statements are anything but very general statements regarding the objectives of the group involved.

When problems have been identified, priorities have not been established for placing an orderly focus of attention on solutions which will have an immediate positive impact, or which will eliminate the most adverse impact, on patient care or clinical performance.

For all practical intents and purposes, the MCE/UR Committee meeting is merely a gathering of most members each month. It very definitely is NOT an effective, fact-finding, problem-seeking/-solving, deliberative body. A much more streamlined and representative approach to QA monitoring must be employed for Letterman Army Medical Center to meet the requirement for its QA program to be problem-focused.

Annual Review

There is no provision for annual review of the LAMC QA process.

Improved Patient Care/Clinical Performance

At the present time, there is no formal documentation of improved patient care or clinical performance being done.

Other Significant Shortcomings

There are two other areas which require attention before the LAMC QA program can be truly comprehensive: utilization review and risk management.

Utilization Review

The utilization review function of the Medical Care Evaluation/Utilization Review Committee at LAMC is, unfortunately, virtually totally neglected. Although there is a very comprehensive and recently reviewed utilization review LAMC regulation on file, it is not being followed.

Risk Management

Although the LAMC risk management program appears to be quite effective with its prevention-oriented approach, there is no written plan for the program which describes its objectives, responsibilities, lines of responsibility and authority, coordination, etc. Some kind of coordination of the various facets of the risk management effort must be made in the form of a documented program memorandum.

The initiation and processing of incident reports is another problem area, as described below:

- There is no LAMC directive pertaining to the proper purpose, initiation, completion, and disposition of the incident form, DA Form 4106.

- The incident reports are initiated primarily by the nursing staff. Very few other LAMC staff members prepare incident reports, at least for appropriate incidents.

- The incident reports on file are usually very patient care oriented rather than being problem-solution oriented. For example, rather than action such as closer surveillance for future hazards to patient safety, action is focused exclusively on the patient who has already been injured, with modified bedrest, x-rays, observation for edema, etc. There is no apparent inquiry into what caused the injury in the first place, nor correcting the causal factors, if any are discovered. In other words, there is action documented, but it is not the indicated corrective action.

- According to Army Regulation 40-400, incident reports are to be forwarded by the CPS' office to the appropriate QA committee for evaluation of the incident and recommended (corrective) action. Committee findings are then to be given to the LAMC Executive Committee for appropriate follow-up. This processing and follow-up is not taking place.

There is also a lack of focus on patient complaints being processed through channels which are intended to be responsive to the plaintiff. Rather than being channeled to a common reception and review point within the organization, patient complaint actions are very fragmented, and are not effectively acted upon by an individual or group with the authority to respond appropriately on the patient's behalf. Patient complaints are heard by the Patient Assistance office, the Inspector General, receptionists, nurses, etc. without a written record being prepared so that the grievance and the action taken or recommended can be properly reviewed and

coordinated by one individual or office charged with that task.

A somewhat related problem is the lack of sensitivity training or similar patient relations programs for LAMC personnel routinely dealing with patients and other LAMC publics.

CHAPTER V

APPLYING THE GOLDEN RULE OF OR/SA: AN APPROXIMATION OF THE OPTIMAL, FEASIBLE QA PLAN

This final portion of the discussion will address recommendations designed to resolve the problems which were identified in the previous chapter. As in the preceding chapters, this segment of the paper will employ the significant requirements of the JCAH QA standard as a discussion framework.

As this point in this problem solving exercise, it is important for the reader to note that a heuristic approach to the development of an optimal feasible solution was used. Since there were no differences between the existing LAMC QA system and the 1981 JCAH QA standard which could not be resolved through some relatively uncomplicated rearrangement of the present resources, improving upon the existing system was preferable to creating an entirely new one. This pragmatic approach offered advantages which a more extensive or complete redesign could not provide: least disruption of the present system, easier acceptance by the participants, and no requirement for additional resources.

Written Plan

A single written plan must be developed to fully integrate the quality assurance program components of medical

care evaluation, utilization review, and risk management. The complete recommendation for this facet of the 1981 JCAH QA requirement--and the objective of this entire problem solving project--may be seen as the Appendix to this paper: a draft Letterman Army Medical Center regulation, titled Quality Assurance: Medical Care Evaluation, Utilization Review, and Risk Management. This proposed written plan includes material on the purpose, scope, coordination, implementation responsibilities, organization chart, annual review provisions, etc. of the new LAMC QA system.

In addition, there are recommendations to amend some portions of LAMC Regulation 15-1: rewriting of the committee/subcommittee purpose statements to make them more specific, directive, and problem-focused; addition of the problem/solution/follow-up format as a required item in the minutes format for each committee/subcommittee; development of purpose statements, member lists, etc. for each departmental subcommittee; inclusion of all required committees; deletion of unnecessary committees; etc.

Comprehensiveness

All clinical patient care areas, as well as all QA monitoring activities, found within Letterman Army Medical Center have been included in the recommended plan. In addition, an antibiotic usage review and evaluation function has been recommended as an additional monitor in the form of either a separate committee, or as a specific responsibility of the Infection Control Committee.

Rather than considering the three areas of medical care evaluation, utilization review, and risk management as separate and distinct, these activities must be--and are--viewed as interdependent components of a complete and fully functional quality assurance system.

To emphasize the complementary and interdependent nature of these components, the title and the body of the proposed LAMC regulation include all three. Further, the former MCE/UR Committee has been replaced by a more comprehensive QA Committee, with a new QA Executive Committee having the leading role in directing the QA system and effort at LAMC.

The QA Executive Committee consists of the Chief, Professional Services as Chairperson, and includes the following Department Chiefs as members--Surgery, Medicine, Nursing --and the Chief, Administrative Services/Executive Officer. This five-member executive committee should prove to be more efficient in operation than the twenty-one member MCE/UR Committee was, particularly in the review of the subordinate committees and the departmental subcommittees. At the same time, it includes membership from key members of the clinical and administrative staffs of the hospital. Also, the four members share the responsibility for reviewing the proceedings of the sixteen subordinate committees and departmental subcommittees with the Chairperson, rather than leaving the CPS to manage that responsibility alone, as in the existing system.

The other specific responsibilities of the QA Executive

Committee include the following:

- Receive and review the reports of all committees and departmental subcommittees subordinate to the LAMC QA Committee.

- Maintain information on the status of all problem/solution/follow-up input received from subordinate committees/departmental subcommittees.

- Provide feedback to subordiante committees/departmental subcommittees which eliminates unnecessary duplication of effort.

- Coordinate the conduct of similar or related QA efforts.

- Establish a recommended priority of problem resolution efforts for the consideration of the LAMC Commander.

- Assign responsibilities for problem resolution efforts which are approved by the LAMC Commander.

- Recommend allocation of LAMC resources for QA.

- Review the progress of follow-up actions.

- Call upon the expertise of the members of the QA Committee, as required.

- Review Therapeutic Agents Board input from its Chairperson, the Chief, Professional Services.

- Review Hospital Education Committee input from its Chairperson, the Chief, Professional Services.

- Review Safety Council input from its Chairperson, the Chief, Administrative Services/Executive Officer.

- Periodically evaluate the quality of support

services not evaluated elsewhere within the QA system at LAMC.

- Insure that patient services provided are necessary, appropriate, and could not have been provided effectively on an outpatient basis.

- Insure the implementation and continuation of a structured discharge planning program.

- Review and evaluate the distribution and adequacy of space; the number and kinds of personnel; and the availability and use of supplies, equipment, and facilities.

- Initiate special concurrent and/or process audits to better identify and assess problem areas, as appropriate.

- Determine the activities to be considered by the utilization review process.

- Monitor and coordinate all risk management activities, and take appropriate action on all risk management issues affecting the quality of patient care/clinical performance at LAMC.

The former Medical Care Evaluation/Utilization Review Committee--now called the Quality Assurance Committee--has the same membership, with two additions. The LAMC Inspector General and the LAMC Staff Judge Advocate have each been added to the QA Committee to enhance its comprehensiveness as a quality assurance information monitoring and processing mechanism.

Because it is so large--some twenty-three members--the QA Committee will meet only quarterly, not each month. At that time, it will review the progress of the QA Executive

Committee; discuss problems, solutions, and follow-up; provide consultation; etc.

The Safety Council and the Therapeutic Agents Board remain as separate and independent bodies, not subordinate to the QA Committee; i.e., status quo. However, the respective Chairpersons of these two councils--both of whom are seated on the QA Executive Committee--are specifically charged with serving as the coordination link between the QA Executive Committee and these other activities.

Problem-focused Approach

A problem-focused approach, i.e., a problem/solution/follow-up format of inquiry and reporting, is a key responsibility for each committee, subcommittee, board, etc.

Minutes of each meeting will specifically enumerate problem/solution/follow-up discussions, or will explain the lack of same. A consistent finding of "no problem" will not be acceptable.

The purpose of each committee/subcommittee should be rewritten to include and emphasize this all-important function.

Recommendations for the establishment of priorities will be forwarded by each subordinate committee/subcommittee for review by the QA Executive Committee. Priority will be given to solutions having an immediate positive impact, or which will eliminate the most adverse impact, on patient care/clinical performance.

The QA Executive Committee has been established to

promote fact-finding and problem-solving at the Quality Assurance Committee level. This group of only five individuals should provide the comprehensiveness of review, active problem-seeking and -solving, and other productivity which is required.

Annual Review

There is a very specific provision for an annual review of the QA plan and program to insure that the program is actually accomplishing its objective--the improvement of patient care/clinical performance toward the optimal level achievable at Letterman Army Medical Center. Attention should be given to variables which can influence the quality of care--changes in clinical or administrative states of the art; available financial, personnel, and facility resources; changes in patient population; progress in the sustained resolution of problems identified; the vigor of problem-seeking; etc.

Gaps or inconsistencies which may discovered or which may develop later must be corrected.

Most important--other than the patient care itself--is a conscientious and creative compliance with the intent of the annual review, and an objective evaluation of the progress in improving patient care which has really taken place.

Improved Patient Care/Clinical Performance

Documentation and demonstration of improved patient care/clinical performance must be shown. Prima facie evidence

of such improvement would include a summary of identified problems, and the resulting successful interventions or solutions. Indirect efforts should be noted, in addition to direct efforts. Quantitative expressions of progress will be especially useful, such as improved morbidity/mortality rates, shorter patient lengths-of-stay, etc.

Risk Management

The risk management facet of the existing LAMC QA system requires two improvements, each of which are addressed or resolved in the recommended LAMC QA regulation:

1. documentation of the risk management effort, i.e., a written plan for it.

2. improved use of incident reports.

A written description of the purpose, scope, responsibilities, etc. associated with the LAMC risk management plan is included in the proposed QA regulation. It includes a description of prevention-oriented activities, as well as the efforts necessary after potential hospital liability incidents have taken place.

The use of incident reports is covered in detail in the proposed LAMC QA regulation. The scope of the origin and application of the incident report has been expanded well beyond that of the existing LAMC QA system, and the significant incident corrective actions recommended and taken are reviewed by the appropriate monitoring committee and the LAMC Executive Committee before the report action is completed.

All patient complaints are to be described in an

incident report, with all such reports reviewed by either the Chief, Professional Services or the Executive Officer, as appropriate.

The LAMC Executive Officer has been appointed as the LAMC Risk Management Officer, while the LAMC Staff Judge Advocate has been appointed as the Risk Manager, or primary risk management operator.

The QA Executive Committee will review all actions of and other developments related to the risk management endeavor.

Utilization Review

The utilization review plan which is part of the existing LAMC QA system as LAMC Regulation 40-401 is a very thorough one, and remained unchanged following a recent staff review. Rather than remain as a separate LAMC directive, however, the content of this regulation has been included as part of the proposed LAMC QA regulation.

The one flaw in the utilization review portion of the existing LAMC QA system is the virtually total lack of compliance with the present regulation. When compliance is achieved, the utilization review component of the new LAMC QA system will be in compliance with all applicable Departmert of the Army and Joint Commission on Accreditation of Hospitals directives.

The LAMC QA Executive Committee will assume the role of assigning appropriate utilization review topics to the subordinate quality assurance committees and subcommittees, and

will also review the study conclusions resulting from such assignments.

CHAPTER VI

CONCLUDING COMMENT

In the course of conducting this problem solving project, two lessons have become conspicuously and abundantly clear.

First, the value of a methodical application of the systems approach to problem solving has become very evident. This fact is reinforced with each successive application of this methodology.

The other observation deals with the quality assurance concept in general. Endeavors to provide the best possible patient care have existed in one form or another for almost 4000 years, yet we are still struggling with the search for a satisfactory QA system. From this abundance of trial, error, and other experience, one point stands out very clearly: regardless of the care and precision with which a QA methodology is developed for use in health care insitiutions, the end result will still ultimately depend upon and be only as good as the effort invested in the actual implementation of the procedure. It is therefore imperative that this aspect of quality assurance is not only noted, but that it is seriously, vigorously, and continuously stressed by those health care providers in positions of authority in the quality assurance system.

APPENDIX

D R A F T

DEPARTMENT OF THE ARMY
LETTERMAN ARMY MEDICAL CENTER
Presidio of San Francisco, California 94129

LAMC REGULATION
NUMBER _____

QUALITY ASSURANCE: MEDICAL CARE EVALUATION, UTILIZATION REVIEW, AND RISK MANAGEMENT

SECTION I. GENERAL PROVISIONS

1. PURPOSE. The purpose of this regulation is to document procedures for the implementation of a formal quality assurance (QA) program at Letterman Army Medical Center.

2. GENERAL. The goal of this quality assurance (QA) program is to raise the level of patient care/clinical performance to the optimum level achievable at LAMC. This goal is to be achieved through the implementation of a comprehensive, problem-focused approach which incorporates the complementary, interdependent components of medical care evaluation, utilization review, and risk management into an effective system of well coordinated and integrated patient care/clinical performance evaluation.

3. SCOPE. The scope of quality assurance activities at LAMC includes all clinical activities related to patient care, and all supporting services and administrative staff.

4. CONCEPT.

a. Committees, subcommittees, councils, and boards.

(1) The following committees will serve as QA monitors for their respective areas of clinical interest, and will report their activities and findings to the LAMC Quality Assurance Committee in accordance with LAMC Regulation 15-1.

(a) Ambulatory Patient Care Committee.

(b) Blood Utilization Committee.

(c) Cardiopulmonary Arrest and Resuscitation Procedures Committee.

(d) Critical Care Committee.

(e) Infection Control Committee.

(f) Tumor Board.

(2) Each patient care department/service will be represented by a departmental QA subcommittee which will monitor departmental/service activities and report to the LAMC Quality Assurance Committee in accordance with LAMC Regulation 15-1.

(3) The Quality Assurance Executive Committee will receive and review reports from subordinate committees and departmental subcommittees for the Quality Assurance Committee, and will report to the Quality Assurance Committee as prescribed in LAMC Regulation 15-1. The QA Executive Committee will be composed of the following individuals:

(a) Chief, Professional Services, Chairperson.

(b) Chief, Department of Surgery, Member.

(c) Chief, Department of Medicine. Member.

(d) Chief, Department of Nursing, Member.

(e) Chief, Administrative Services/Executive Officer, Member.

The QA Executive Committee will submit a report of its activities to the LAMC Executive Committee.

(4) The QA Committee will function as prescribed in LAMC Regulation 15-1.

(5) Other LAMC committees having a significant role in the LAMC QA program are:

(a) Health Consumer Advisory Committee.

(b) Safety Council.

(c) Therapeutic Agents Board.

(d) Hospital Education Committee.

(e) Credentials Committee.

All participating committees will function as prescribed in LAMC Regulation 15-1. An organization chart depicting the relationship of the monitoring committees and the assurance committee to the LAMC Commander is shown in Figure 1.

b. Sources of data. Data sources for the conduct of monitoring activities by the designated committees/subcommittees, councils, and boards include but are not limited to those listed in Figure 2.

c. Problem-focused approach. The methodology of the LAMC QA program will be the identification and sustained resolution of known, suspected, or potential problems. Accordingly, each committee/subcommittee, council, or board performing a QA monitoring function will prepare a report comment in its monthly minutes to the effect that a QA problem was/was not identified. When a problem is identified, the discussion will include an appropriately titled paragraph with a summary of the problem definition, proposed solution alternatives, and a plan for the documented follow-up or monitoring of resolution progress. As progress is made in resolving problems, such progress will be reported until a sustained and satisfactory resolution has been attained. A consistent finding of "no problem" will be unacceptable.

d. Priorities. Problem solving efforts will be assigned priorities by the LAMC Commander. Priorities will be influenced by the following factors:

(1) Resources required.

(2) Resolutions which will have the most immediate positive impact on improving the quality of patient care/clinical performance.

(3) Resolutions which will alleviate the most adverse impacts on patient care/clinical performance.

e. Annual review. In January of each year, the QA Executive Committee will conduct an annual review of the LAMC QA program to insure that progress is being made to reduce deviation between the quality of care actually provided and the optimal care achievable at LAMC. This annual review will focus on the portions of the QA plan and system which may be overtaken by time and events: e.g., changes in clinical or administrative states of the art; availability of fiscal, personnel, and facility resources; changes in patient population; rate of progress in the sustained resolution of problem areas; cost effectiveness of the program; comprehensiveness of the program; changes in QA procedures; etc.

5. RESPONSIBILITIES. Committee/subcommittee, council, board, and individual responsibilities for each component of the LAMC QA system are outlined in the following sections of this directive:

a. SECTION II. MEDICAL CARE EVALUATION.

b. SECTION III. UTILIZATION REVIEW.

c. SECTION IV. RISK MANAGEMENT.

SECTION II. MEDICAL CARE EVALUATION

1. RESPONSIBILITIES.

a. Quality Assurance Executive Committee.

(1) Receive and review the reports of all committees and departmental subcommittees subordinate to the LAMC QA Committee.

(2) Maintain information on the status of all problem/solution/follow-up input received from subordinate committees/departmental subcommittees.

(3) Provide feedback to subordinate committees/departmental

subcommittees which eliminates unnecessary duplication of effort.

(4) Coordinate the conduct of similar or related QA efforts.

(5) Establish a recommended priority of problem resolution efforts for the consideration of the LAMC Commander.

(6) Assign responsibilities for problem resolution efforts which are approved by the LAMC Commander.

(7) Recommend allocation of LAMC resources for QA.

(8) Review the progress of follow-up actions.

(9) Call upon the expertise of the members of the QA Committee, as required.

(10) Review Therapeutic Agents Board input from its Chairperson, the Chief, Professional Services.

(11) Review Hospital Education Committee input from its Chairperson, the Chief, Professional Services.

(12) Review Safety Council input from its Chairperson, the Chief, Administrative Services/Executive Officer.

(13) Periodically evaluate the quality of support services not evaluated elsewhere within the QA system at LAMC.

b. Quality Assurance Committee.

(1) Review the progress of the LAMC Medical Care Evaluation program in January of each year.

(2) Provide consultation to the QA Executive Committee, as required.

(3) Assist in the identification of problem definitions, formulation of solution alternatives, and follow-up on the progress of solutions.

c. Quality Assurance Committee Subordinate Committees and Departmental Subcommittees.

(1) Review the quality of medical care in their respective areas of

patient care/clinical performance.

(2) Identify and define medical care problems, propose alternative solutions, and follow up on the progress of the solutions until a satisfactory, sustained resolution has been achieved.

(3) Report activities to the QA Executive Committee.

2. METHODOLOGY. The following process will be employed:

a. Identification of important or potential medical care problems. This will be accomplished by all committees and departmental subcommittees subordinate to the LAMC QA Committee, and reported to the QA Executive Committee in the format prescribed in LAMC Regulation 15-1.

b. Assessment of the causes and scope of problems related to medical care.

c. Determination of the priorities for investigating and resolving patient care/clinical performance problems.

d. Implementation of solutions for patient care problems which have been determined as sufficiently high in priority to warrant the expenditure of LAMC resources.

e. Monitoring of activities to assure progress toward a sustained solution until a satisfactory or complete level of problem resolution is attained.

SECTION III: UTILIZATION REVIEW

1. GENERAL.

a. Utilization review (UR) of patient care is the ongoing evaluation of health resources management and the appropriateness of admissions, services ordered and provided, length of stay, discharge planning and practice, and outpatient services. Its principal concern is cost containment.

b. Related definitions.

(1) Criteria: Predetermined elements against which aspects of the quality of a medical service may be compared.

(2) Standards: Professionally developed expressions of the range of acceptable variations for a norm or criterion.

(3) Norms: Numerical or statistical measures of usually observed performance; e.g., length of stay.

(4) Concurrent: In the context of utilization review, the daily review of charts for admission and length-of-stay certification purposes, as practiced by military and civilian hospitals to comply with Medicare and Medicaid requirements.

(5) Ongoing: Continuing reviews and analyses of overall performance and trends in the quality of care as practiced at Army medical treatment facilities.

2. RESPONSIBILITIES.

a. Quality Assurance Executive Committee.

(1) Insure that patient services provided are necessary, appropriate, and could not have been provided effectively on an outpatient basis. The committee will address the following subjects:

(a) Appropriateness and medical necessity of admission.

(b) Appropriateness and medical necessity of continued stays.

(c) Appropriateness and medical necessity of supportive services.

(2) Insure the implementation and continuation of a structured discharge planning program and routinely monitor the effectiveness of mechanisms employed to guarantee continuity of care and follow-up.

(3) Review and evaluate the distribution and adequacy of space; the number and kinds of personnel employed; and the availability and use

of supplies, equipment, and facilities.

(4) Initiate special concurrent and/or process audits, as appropriate, to better identify and assess problem areas, and recommend solution alternatives which are suitable.

(5) Determine the activities to be considered and review their selection each quarter. Special emphasis will be given to high cost areas and/or other problem areas presented by the LAMC staff. The QA Executive Committee should determine specific diagnoses or symptoms, problems, procedures, or pracitioners to be included or excluded for these UR activities.

3. METHODOLOGY.

a. LAMC will employ the following UR mechanisms:

(1) Inclusion of "justification for admission" criteria in medical care evaluation studies.

(2) Inclusion of length-of-stay parameters in medical care evaluation studies.

(3) Review of the Long Term Patients Roster.

(4) Review of practices:

(a) Relating day-of-admission to day-of-operation in surgical cases.

(b) Relating interval between admission and diagnostic tests.

(c) Determining the effect of preadmission workups on length-of-stay.

(d) Analysis of patterns of post-operative and post-partum stays.

(e) Analysis of administrative delays in disposition.

(f) Analysis of discharge practice and length-of-stay as related to specific diagnoses.

(5) Blood utilization review.

(6) Drug utilization review.

(7) Consultation utilization review.

(8) Utilization review of services ordered and provided:

(a) Ongoing: Clinical department/service meetings to discuss patient care plans and objectives.

(b) Retrospective: Inclusion of specific criteria in outcome audits and analysis of duplication of diagnostic tests.

(9) Review of emergency services.

(10) Review of outpatient and ambulatory care services.

(11) Review of special care units.

(12) Preparation of Schedule X.

(13) Review of the UR Program (URP) Reports.

b. Additional UR mechanisms will be adopted as deemed necessary and appropriate by the QA Executive Committee.

c. Discharge planning will be initiated as soon as it is practical, and will include provision for referral to a more economical level of care, or discharge. The following mechanisms will be used for insuring appropriate discharge planning:

(1) Patient instruction.

(2) Medical and administrative agency processing concurrent with treatment.

(3) Early decision regarding military patients who may be separated for physical disability reasons.

(4) Projected Disposition Roster.

(5) Coordination of nursing care plans with medical care plans.

d. The following types of documentation will be used for conducting UR functions:

(1) Profiles of diagnoses, procedures, practitioners, and supportive

services.

(2) Results of medical care evaluation studies.

(3) Patterns of resource utilization.

SECTION IV. RISK MANAGEMENT

1. GENERAL.

a. Risk is the possibility of the loss of financial assets by the federal government, including the possibility of liability for injury to patients, visitors, and employees.

b. Risk management is the administratively directed program designed to prevent injury or other adverse events, and to reduce and control financial loss.

c. Risk management activities can be divided into two major classifications:

(1) Preventive liability activities: Efforts to minimize the likelihood of injury to patients, visitors, and employees associated with medical care delivery prior to injury or incident.

(2) Liability control activities: Detection, reporting, analysis, and follow-up activities designed to minimize the cost of potential liability after injuries or other incidents have occurred. This can frequently be accomplished by prompt treatment of an accidental injury, or by appropriate information and/or other assistance for the patient.

2. RESPONSIBILITIES.

a. The LAMC Staff Judge Advocate (SJA) will serve as the LAMC Risk Manager, or risk management operator.

b. The LAMC Executive Officer (XO) will serve as the LAMC Risk Management Officer, or overall supervisor for the Risk Manager and all LAMC risk management activities.

3. METHODOLOGY.

a. Preventive liability activities. The following preventive liability activities will be the responsibility of the LAMC Risk Manager (SJA):

(1) Serve as the principal risk management consultant to the LAMC Commander and the LAMC Risk Management Officer.

(2) Serve as the principal risk management concultant to the QA Executive Committee.

(3) Prepare and present, or coordinate arrangements for the presentation of, risk management/preventive liability seminars for in-service training programs, officer basic courses, legal medical symposia, etc.

(4) Maintain a risk management data analysis information system designed to answer the following type of questions:

- What types of incidents are occurring?
- Are these incidents the result of accidents, carelessness, high-risk procedures, etc.?
- What is the realtive severity of these incidents?
- What is the relative frequency of these incidents?
- Where are these incidents occurring?
- Are these incidents preventable?
- What is the status of claims and/or lawsuits initiated by LAMC patients, visitors, etc.?
- Are trends developing?
- If trends are developing, what are they and what do they indicate? It will be important to distinguish custodial liability (e.g., potential liability for injuries from patient falls) from clinical liability (e.g., potential liability for the adverse effects of treatment, incomplete

diagnosis, incorrect diagnosis, etc.)

b. Liability control activities.

(1) DA Form 4106, Report of Unusual Occurrence (the incident report) will be promptly prepared for any "incident," i.e., any happening, with or without injury, involving a patient, visitor, or employee mishap, or serious expression of dissatisfaction. A reportable incident is the result of a patient (or patient's relative, visitor, or companion) percieving, correctly or incorrectly, that the patient has in some manner been slighted, neglected, mistreated, or injured. Examples of incidents include sudden or unexpected death; injury, or potential injury, as a result of a diagnostic or therapeutic procedure; medication prescription, dispensing, or administration error; medication reaction; patient fall (for any reason and even without apparent harm); mishap due to faulty equipment or environment (e.g., a broken wheelchair, a loose railing, an unmarked step); expression of dissatisfaction with medical care or other attention provided or not provided; serious complaints about delays; apparent lack of, or malfunction of, any system designed to assist the patient in some reasonable way (e.g., poor directional signs, discourteous employees, misleading or inadequate information, etc.); hint or expression of intent to initiate a claim against the federal government; a request from an attorney for information about a patient; the potential for any such incident; etc. The incident report will be initiated by any individual from the activity concerned in three copies in sufficient time for an initial report to be received by LAMC headquarters prior to 0730 hours of the following day. One copy should be forwarded to the Chief, Professional Services; one copy should be forwarded to the Executive Officer; and one copy should be retained by the

initiating department or service. The CPS will forward each significant and completed report to the appropriate QA committee for corrective action. Committee findings will be submitted through QA channels to the LAMC QA Executive Committee for action and follow-up. (See AR 40-400, para 10-12.1c.)

(2) The Risk Management Officer (XO) shall:

(a) Review all incident reports.

(b) Contact the LAMC Risk Manager (SJA) when incidents are reported.

(c) Keep the QA Executive Committee informed on the status of preventive liability activities and liability control activities, especially the following: potentially compensable events (incidents); status of claims or lawsuit actions; trends in incidents; and other information pertaining to risk management problems, solutions, or follow-up.

(d) Insure coordination between the Safety Council and the QA Executive Committee.

(3) The Risk Manager (SJA) shall:

(a) Review all incident reports.

(b) Initiate an investigation of all incidents involving either a request for information from an attorney, or an expressed or implied intent to initiate a claim against the federal government.

(c) Contact the Armed Forces Institute of Pathology Department of Legal Medicine for case review of incidents involving unusually large dollar amount claims.

(4) The QA Executive Committee shall monitor and coordinate all risk management activities, and take appropriate action on all risk management issues affecting the quality of patient care/clinical performance at LAMC.

SECTION V. CONCLUSION

Referances:

1. AR 40-400.
2. LAMC Regulation 15-1.
3. JCAH Accreditation Manual for Hospitals, latest annual edition.

The proponent element of this regulation is the Chief, Professional Services. Users are invited to send comments to the Commander, LAMC, ATTN: AFZM-MDZB.

FOR THE COMMANDER:

2 Incl
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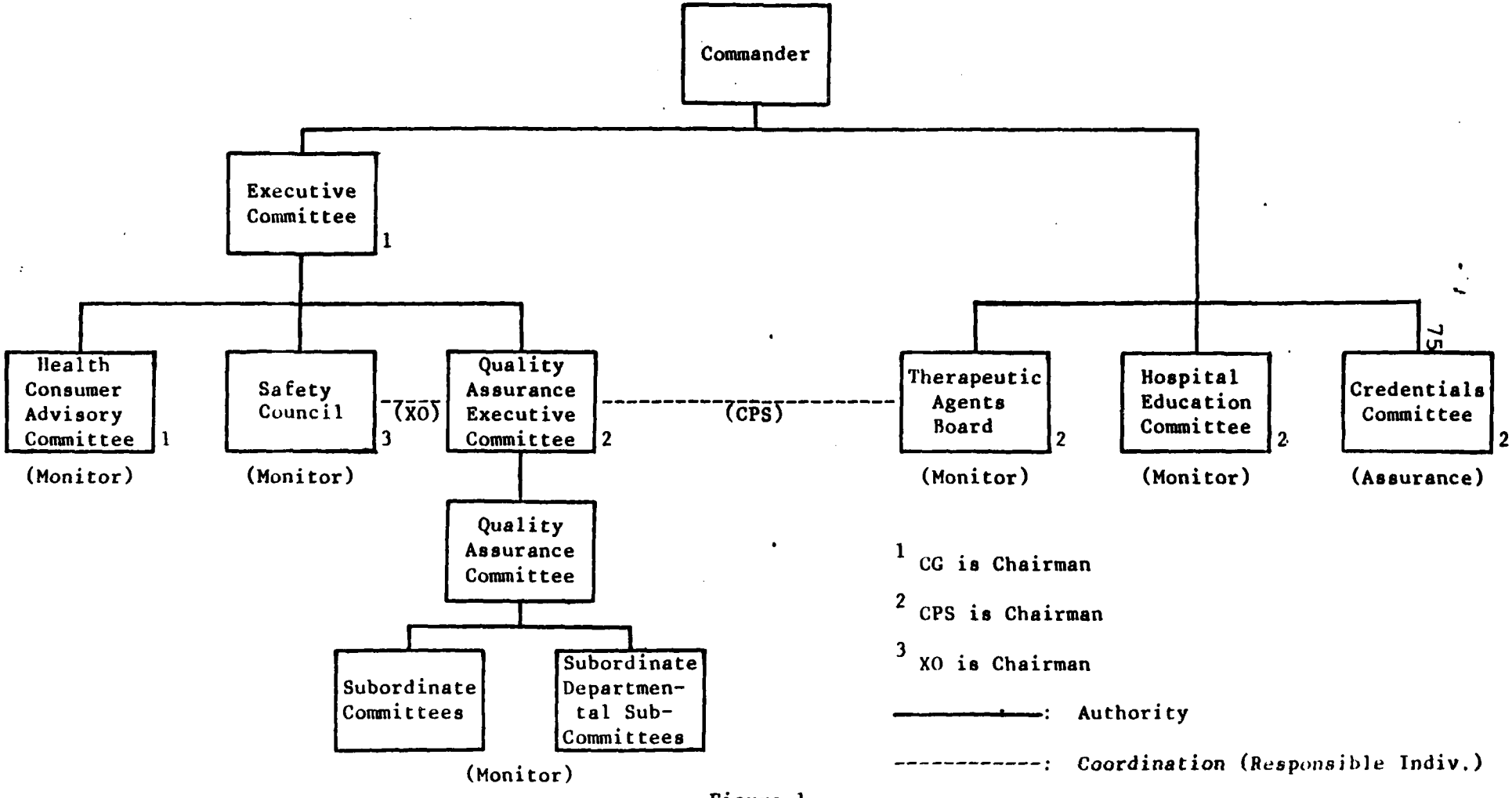
Commander
Executive Committee
1
Health Consumer Advisory Committee
1
(Monitor)
Safety Council
3
(Monitor)
(XO)
Quality Assurance Executive Committee
2
(CPS)
Therapeutic Agents Board
2
(Monitor)
Hospital Education Committee
2
(Monitor)
Credentials Committee
2
(Assurance)
Quality Assurance Committee
Subordinate Committees
Subordinate Departmental Sub-Committees
(Monitor)
1 CG is Chairman
2 CPS is Chairman
3 XO is Chairman
: Authority
: Coordination (Responsible Indiv.)

Figure 1

DATA SOURCES

Medical Records

Concurrent patient care monitoring

Utilization review studies and data

Professional Standards Review Organization (PSRO) information

Health Services Command (HSC) Command Performance Summary information

Financial management studies

Risk management information

Review of prescriptions

Audit conclusions

Patient surveys

Staff surveys

Third party payer/fiscal intermediary information

Professional Activities Study (PAS) information

Monitoring activity (committees, boards, etc.) proceedings

Incident reports

Literature reviews

Figure 2

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